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IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, *et al.*,

Petitioners,

—v.—

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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MOTION OF THE AMERICAN HOSPITAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE*

Pursuant to Rule 42 of the Rules of this Court, the American Hospital Association hereby respectfully moves this Court for leave to file the attached brief *amicus curiae* in the above-captioned case. The brief urges reversal of the decision of the Court of Appeals for the Ninth Circuit in the above-entitled case.

Counsel for the petitioners have consented to the filing of the attached brief. Counsel for the respondent have not consented to its filing.

The American Hospital Association

The American Hospital Association ("AHA") is a nonprofit organization which represents some 7,500 institutional members (hospitals and other health care institutions) and more than 16,000 personal members. The purpose of the AHA is stated in its first bylaw:

> "[The AHA] object shall be to promote the welfare of the public through its leadership and its assistance to its members in the provision of better health care services for all the people."

The organization's principal interest is the care which patients receive from the hospitals of this country.

AHA provides a wide range of professional services in order to develop "better health services for all the people." It, along with the American College of Surgeons, the American College of Physicians, and the American Medical Association, is a sponsor of the Joint Commission on Accreditation of Hospitals, an organization which assists hospitals in their efforts to provide optimal levels of care. AHA conducts a considerable number of educational programs, such as workshops, institutes and meetings, to assist its members in providing efficient hospital care. It publishes and distributes substantial amounts of professional literature on the same subject. AHA conducts the most extensive data collection program in the hospital field and a wide range of hospital research projects.

AHA also represents its membership with respect to governmental matters before the Congress and such federal agencies as the Department of Health, Education, and Welfare.

The Interest of the American Hospital Association as *Amicus Curiae*

The decision of the Court of Appeals for the Ninth Circuit is of profound significance to all nonprofit hospitals and the AHA. It is the first judicial application of the Nonprofit Institutions Act to hospitals. It has massive precedential consequences. The decision attempts to list every type of drug use by nonprofit hospitals and then to determine, in broad and absolute terms, the application of the Act's Robinson-Patman exemption to each type of drug use. This is not a decision limited to a particular type of drug usage by a particular type of nonprofit hospital. The decision threatens to affect all nonprofit hospitals, not just in the Ninth Circuit, but all across the nation.

Yet it is the nonprofit hospitals whose interests have not been represented in the prior proceedings in this action. With all respect to the respondent assignee of various retail druggists, and to the petitioner drug manufacturers, it is the nonprofit hospitals represented by AHA that would feel the real brunt of the decision.

The Nonprofit Institutions Act was enacted to confer important benefits upon nonprofit hospitals, namely, the opportunity to purchase drugs and other supplies at special low prices in order to enable the hospitals to operate as inexpensively as possible. It is surely appropriate that the AHA be given the opportunity to convey to the Court its views with respect to the application of this important exemption to nonprofit hospitals.

The AHA believes that the decision is fundamentally unsound. It is inherently illogical. It relies on a rigid, categorical approach to determine which drugs are pur-

chased for a hospital's "own use" and thereby qualify for the exemption, and which drugs do not qualify for the exemption even though they are used to treat sick people in the performance of admittedly proper hospital functions. The eight listed categories do not even cover the present range of hospital drug usage. And the arbitrary line of demarcation between exempt and nonexempt categories is never explained; it is in fact inexplicable.

The practical consequences of compliance with the decision would be enormous and costly. No matter how the decision were implemented, it would result in higher drug costs, higher administrative costs and substantive disruption of services and supply procedures.

The AHA further believes that the decision of the Court of Appeals is premised on an inaccurate understanding of the functions of a hospital in contemporary society. Public and private health care experts, the Congress, and the federal health care agencies agree that the present gap in health care services can only be narrowed if the hospital becomes the primary source for total community health services. The decision is flatly inconsistent with the ongoing expansion of outpatient and ambulatory services by hospitals—a vital development in the delivery of health care in this country.

This Court granted AHA's motion for leave to file a brief *amicus curiae* in support of the petition for a writ of certiorari in this case. Now that the case is being heard on the merits, AHA wishes to bring to the Court's attention the experience and views of the nonprofit hospitals who would be affected by the decision most directly.

Accordingly, the American Hospital Association respectfully urges this Court to grant its motion for leave to file its brief as *amicus curiae*.

Respectfully submitted,

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Commonwealth v. *Tilley*, 306 Mass. 412, 28 N.E.2d 245 (1940) 10

De Lima v. *Bidwell*, 182 U.S. 1 (1901) 10

Eastern Kentucky Welfare Rights Organization v. *Simon*, 506 F.2d 1278 (D.C. Cir. 1974), *cert. granted*, 95 S. Ct. 1974 (1975) (Nos. 74-1110 and 74-1124) 9, 12

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Fortnightly Corp. v. *United Artists Television, Inc.*, 392 U.S. 390 (1968) 11

Heart of Atlanta Motel, Inc. v. *United States*, 379 U.S. 241 (1964) 9

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Logan Lanes, Inc. v. *Brunswick Corp.*, 378 F.2d 212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967) 5, 6, 8, 23, 24, 25

Newman v. *Arthur*, 109 U.S. 132 (1883) 10

Pickhardt v. *Merritt*, 132 U.S. 252 (1889) 10

Jerome H. Remick & Co. v. *Am. Auto. Accessories Co.*, 5 F.2d 411 (6th Cir.), *cert. denied*, 269 U.S. 556 (1925) 10

Todd v. *Citizens' Gas Co.*, 46 F.2d 855 (7th Cir.), *cert. denied*, 283 U.S. 852 (1931) 10

Statutes and Regulations:

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Medical Facilities Construction and Modernization Amendments of 1970, 42 U.S.C. § 291c(a)(5) 14

National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 2(a)(4), 88 Stat. 2226 14

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Nonprofit Institutions Act, 15 U.S.C. § 13c (1970) ....*passim*

Public Health Service Amendments of 1968, Pub. L. No. 90-574, 82 Stat. 1005 14

Robinson-Patman Act, 15 U.S.C. §§ 13 *et seq.* (1970) ..*passim*

Internal Revenue Service

Rev. Rul. 68-376, 1968-2 CUM. BULL. 246 .....25, 4a-7a

Rev. Rul. 69-267, 1969-1 CUM. BULL. 160 28

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Rev. Rul. 69-269, 1969-1 CUM. BULL. 160 28

Cost of Living Council Regulations, 39 Fed. Reg. 2670 (1974) 14

Legislative Materials:

H.R. Rep. No. 2161, 75th Cong., 3d Sess. (1938) 4, 8

S. Rep. No. 1769, 75th Cong., 3d Sess. (1938) 4, 8

S. Rep. No. 1454, 90th Cong., 2d Sess. (1968) 14

Other Authorities:

37 Soc. Sec. Bull. No. 2, Table 2 (February 1974) 19

Board of Trustees, Am. Hosp. Ass'n, *Statement on the Changing Hospital and the American Hospital Association,* 39 HOSPS., July 1, 1965, at 35 13

Bodenheimer, *Patterns of American Ambulatory Care,* VII INQUIRY, Sept., 1970 at 26 17

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Brodie & Graber, *Institutional Pharmacy Practice in the 1970's,* 28 AM. J. HOSP. PHARMACY 240 (1971) 13, 27

CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE (1975) 14

Clarke, *Medications for Outpatients: Operating a Successful Dispensary,* 20 HOSPS., Oct., 1946, at 60 9

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES (1967) 14

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, INCLUSION OF PHARMACEUTICAL SERVICES IN HEALTH MAINTENANCE AND RELATED ORGANIZATIONS, DHEW Publication No. (HSA) 74-13017 (1974) 26

Editorial, 216 J.A.M.A. 972 (1971) 14

Editorial, *The Hospital's Responsibility for Primary Care,* 2 HOSP. MED. STAFF, Jan., 1973, at 1 12

Madden, *Evaluation of Outpatient Pharmacy Patient Counselling,* NS13 J. AM. PHARMACEUTICAL ASS'N 437 (1973) 29

Marston, *Compliance With Medical Regimens: A Review of the Literature,* 19 NURSING RESEARCH 312 (1970) 28

Martin, *Control of Out-Patient Service and Charges,* HOSPS., Sept., 1942, at 85 9

Merrill, *Hospital Pharmacy and Out-Patient Department: The Physician's Point of View,* HOSPS., June, 1941, at 33 9

PAGE

NATIONAL ADVISORY COMMISSION ON HEALTH FACILITIES, A REPORT TO THE PRESIDENT (1968) 14

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FINANCIAL PLANNING IN AMBULATORY HEALTH PROGRAMS, Publication No. (HSM) 73-3027 (1973) 14

Perkoff & Anderson, *Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, VIII MED. CARE 309 (1970) 17

Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE (1975) 11, 12, 15, 1a-3a

REPORT OF THE NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES (1967) 14

F. ROWE, PRICE-DISCRIMINATION UNDER THE ROBINSON-PATMAN ACT (1962) 27

Sharpe & Mikeal, *Patient compliance with antibiotic regimens*, 31 AM. J. HOSP. PHARMACY 479 (1974) 28

Somers, *Only the hospital can do it all—now*, 119 MOD. HOSP., July, 1972, at 95 13

H. M. & A. R. SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS (1967) 12

Stewart & Cluff, *A review of medication errors and compliance in ambulant patients*, 13 CLINICAL PHARMACOLOGY AND THERAPEUTICS 463 (1972) 29

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BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Interest of *Amicus Curiae*

The interest of the American Hospital Association as *amicus curiae* is set forth in the preceding motion for leave to file this brief.

Question Presented

Is the Nonprofit Institutions Act exemption for drugs purchased by nonprofit hospitals "for their own use" limited solely to drugs dispensed to inpatients and patients in the emergency clinic?

Statement of the Case

1. *The Proceedings Below*

Respondent, as the assignee of claims from sixty retail pharmacies, filed this action against twelve drug manufacturers seeking treble damages and injunctive relief. Respondent alleged, *inter alia,* that petitioners had engaged in unlawful price discrimination in violation of the Robinson-Patman Act, 15 U.S.C. §§ 13 *et seq.* (1970), by selling drugs to nonprofit hospitals at prices lower than those offered to commercial retail pharmacies.

Petitioners moved for summary judgment on this claim on the ground that the Nonprofit Institutions Act, 15 U.S.C. § 13c (1970), exempts drug purchases by nonprofit hospitals from the application of the Robinson-Patman Act. The District Court agreed and granted petitioners' summary judgment motion on May 25, 1973. (Tr. 5/25/73 at 88-99) The Court of Appeals for the Ninth Circuit, however, disagreed and vacated the judgment of the District Court on December 26, 1974. 510 F.2d 486.

The drug manufacturers filed a petition for rehearing, and the American Hospital Association sought to file a brief in support of their petition. On March 11, 1975, the Court of Appeals denied both the petition for rehearing and AHA's motion for leave to file its brief as *amicus curiae.* Thereafter, the drug manufacturers petitioned this Court for a writ of certiorari. The AHA sought leave to support the petition *amicus curiae.* On June 23, 1975, the writ, and AHA's motion for leave to file its brief were granted.

2. *The Decision of the Court of Appeals*

The Court of Appeals vacated the judgment below because it interpreted the scope of the Nonprofit Institutions Act ("the Act" or "Section 13c") more narrowly than the District Court. The issue, as framed by the Court of Appeals, was whether each of eight categories of drugs purchased by hospitals was "for their own use" within the meaning of Section 13c. The appellate court concluded that only two categories—drugs dispensed to inpatients and to emergency clinic patients—were for the hospitals' "own use," and hence covered by the Section 13c exemption to the Robinson-Patman Act. The court conceded that the remaining six categories, including dispensation of drugs to outpatients at outpatient clinics, to departing inpatients as take-home prescriptions, and to other patients and users of medication, were "a proper and useful community service and thus can be regarded as a proper hospital function." 510 F.2d at 489. But the court held without explanation that such uses were not the hospitals' "own use" and therefore did not qualify for the Section 13c exemption:

> "Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." *Id.*

Summary of Argument

The Nonprofit Institutions Act exempts from the price discrimination provisions of the Robinson-Patman Act purchases by hospitals and other nonprofit institutions of "supplies for their own use." The issue in this case is whether the Nonprofit Institutions Act exemption is limited solely to *horizontal* drug usage, that is, to drugs dispensed to inpatients and emergency clinic patients, and is inapplicable to *vertical* drug usage, that is, to drugs dispensed to other categories of sick persons, such as those who are treated in outpatient clinics.

The Ninth Circuit summarily concluded that only drugs dispensed to inpatients and emergency clinic patients qualify for the Robinson-Patman exemption. All other drugs purchased by hospitals, though concededly used to perform "proper hospital function[s]," were deemed to be outside the scope of the exemption.

1. The Ninth Circuit would confine the scope of the Section 13c exemption to the principal activities performed by hospitals nearly forty years ago, when the exemption was enacted. Such a frozen interpretation of the statute would be inconsistent with its broad beneficent purposes. The legislative history makes clear that the purpose for the exemption lay in the nonprofit character of the beneficiary institutions, not in the particular activities of such institutions in 1938.[1] The Ninth Circuit's static reading would frustrate the intent of Congress to permit nonprofit insti-

[1] H.R. Rep. No. 2161, 75th Cong., 3d Sess. (1938); S. Rep. No. 1769, 75th Cong., 3d Sess. (1938).

tutions "to operate as inexpensively as possible."[1] The Section 13c exemption should be coterminous with the contemporary functions of the beneficiary institutions.

2. The hospital of today offers a wide range of health care services. At the urging of health care experts and the Federal Government, and in response to a growing gap between health care needs and health care resources, it is providing more and more care through outpatient clinics and other ambulatory care facilities.

3. The Ninth Circuit decision is incompatible with these important developments in the delivery of health care. By means of a rigid, categorical approach, the decision would deny the Section 13c exemption to drugs used in treating outpatients and in performing other proper hospital functions. There is no difference between a hospital's use of drugs in treating inpatients and in treating outpatients. In both cases, the hospital is using the drugs to cure sick people. In neither case does the hospital "consume" the drug. In both cases, it is the patient—inpatient or outpatient—who does so. In both cases the hospital purchases the drug for resale to the patient. And in both cases the hospital is engaging in a "proper hospital function," as the Court of Appeals conceded. By what logic, then, can the Section 13c exemption be accorded to drugs used to treat inpatients but denied to drugs used to treat outpatients?

4. Section 13c was intended to confer benefits upon certain nonprofit institutions. However, the decision below would convert Section 13c benefits into burdens of con-

[1] *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 216 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967).

siderable magnitude. The decision would oblige hospitals either to create and operate duplicate inventory and distribution systems for drugs and other hospital supplies, or to trace the uses to which a single inventory of drugs and supplies are put. The sheer quantity of drugs and supplies stocked by a hospital, and the multiplicity of suppliers furnishing them, would make either option a formidable administrative task. Alternatively, a hospital could simply pay higher prices for all of its drugs and other supplies, and thus forego all of the benefits which Section 13c was intended to confer.

5. The decision below is wrong not merely in result but in approach. A categorical methodology is simply unsuited to Section 13c. The controlling question should not be whether there are six or eight or ten categories of hospital drug usage, or whether each category involves hospital "consumption" of drugs.

Rather, the controlling question should be this: What is the *primary purpose* of the drugs purchased by the hospital? If the primary purpose is the treatment of hospital patients or the performance of other legitimate hospital functions, then the Section 13c exemption should apply to all drugs purchased by the hospital.

The primary purpose test, adopted by the Ninth Circuit in an earlier decision, *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, *cert. denied*, 389 U.S. 898 (1967), is eminently sensible and should be endorsed by this Court. It would accord nonprofit institutions the price benefits Congress intended to confer without shackling their ability to fulfill their institutional purposes. It would make it unnecessary for the judiciary to determine what are proper institutional functions, and to identify every use to which

every nonprofit institution purchase is put. It would also eliminate the illusory distinction between purchases for an institution's "proper function" and purchases for its "own use."

6. It is uncontroverted that the drugs in issue were purchased primarily for the treatment of hospital patients. The treatment of hospital patients is unquestionably a proper activity for a hospital. Therefore, we submit, the Section 13c exemption applies to all of the drugs in issue. The Ninth Circuit's contrary holding should be reversed.

ARGUMENT

I.

The Nonprofit Hospital Exemption Is Coextensive With the Functions of a Hospital in Contemporary Society.

The Nonprofit Institutions Act, 15 U.S.C. § 13c (1970), was enacted in 1938 to exempt hospitals and other nonprofit institutions from the price discrimination prohibitions of the Robinson-Patman Act in order to allow such institutions to purchase their supplies on preferential terms. It provides that:

> "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

As the Court of Appeals for the Ninth Circuit has interpreted this provision, the Section 13c exemption would be confined to the principal activities performed by hospitals

nearly 40 years ago. Without reference to the realities of modern-day practice, the court determined that only drugs provided by hospitals to inpatients and emergency clinic patients may be said to have been purchased by the hospital for its "own use," within the meaning of Section 13c. All other hospital uses of drugs and other supplies—such as drugs used by hospitals in treating outpatients—though conceded to be "proper hospital function[s]" are nevertheless held to be outside the scope of the exemption.

This frozen definition of a hospital's "own use" of drugs is inconsistent with the broad beneficent purposes of the statutory exemption. The legislative history of the Nonprofit Institutions Act makes clear that the purpose and justification for the exemption lay in the nonprofit character of the beneficiary institutions listed in the law, not in the particular activities of such institutions in 1938:

> "The committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interfered with by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, *because of the character of the institution,* do not fall under the ban of the act." [1]

Furthermore, "[t]he underlying intent of granting such an exemption was undoubtedly to permit institutions which are not in business for a profit to operate as inexpensively as possible." [2] Congress did not intend to limit a nonprofit institution's "own use" of supplies to those particular activities which schools, libraries, churches and hospitals were in fact conducting on the date of enactment of Section 13c.[1] Such static statutory construction would substantially impair the ability of the beneficiary institutions to continue to operate inexpensively under the changed circumstances which inevitably come with the passage of time.

[1] H.R. Rep. No. 2161, 75th Cong., 3d Sess. (1938) (emphasis supplied). *See also,* S. Rep. No. 1769, 75th Cong., 3d Sess. (1938).

[2] *Logan Lanes, Inc.* v. *Brunswick Corp.,* 378 F.2d 212, 216 (9th Cir.), *cert. denied,* 389 U.S. 898 (1967).

The Court of Appeals for the D.C. Circuit recently reached the same conclusion in an analogous context in *Eastern Kentucky Welfare Rights Organization* v. *Simon.*[2] The issue was whether the term "charitable," as used in § 501(c)(3) of the Internal Revenue Code, was to be restricted to its narrow sense of relief of the poor. The court held that definitions of charitable institutions must change with the times:

> "We cannot conclude, as did the district court, that Congress intended the [narrow] construction. While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society." [3]

[1] Though not as predominant or important as they are today, outpatient departments were nevertheless an integral part of the hospital forty years ago. In 1941, one physician wrote, "It is almost superfluous to emphasize that the pharmacy and out-patient department are among the most essential services of a hospital." Merrill, *Hospital Pharmacy and Out-Patient Department: The Physician's Point-of-View,* Hosps., June, 1941, at 33. *See also,* Clarke, *Medications for Outpatients,* 20 Hosps., Oct., 1946, at 60; Martin, *Control of Out-Patient Service and Charges,* Hosps., Sept., 1942, at 85.

[2] 506 F.2d 1278 (D.C. Cir. 1974), *cert. granted,* 95 S. Ct. 1974 (1975) (Nos. 74-1110 and 74-1124).

[3] *Id.* at 1287-88 (footnote omitted); *cf. Heart of Atlanta Motel, Inc.* v. *United States,* 379 U.S. 241, 249-58 (1964).

The courts have consistently refused to circumscribe the scope of a statute by reference to the conditions in existence at the time of its enactment.[1] In *Browder* v. *United States,* 312 U.S. 335 (1941), this Court was asked to set aside a criminal conviction for the use of a passport which had been obtained by false statements. The defendant had used the passport to reenter the United States, a use that had not been customary at the time the criminal statute was enacted. It was therefore argued that Congress had not intended to punish uses such as that for which the defendant was convicted.

The Court rejected this contention:

> "Old laws apply to changed situations. The reach of the act is not sustained or opposed by the fact that it is sought to bring new situations under its terms. While a statute speaks from its enactment, even a criminal statute embraces everything which subsequently falls within its scope."[2]

It is a basic rule of statutory construction that a "statute may be applied to new situations not anticipated by Congress, if, fairly construed, such situations come within its intent and meaning."[3] Thus, we submit, television sets purchased by schools and Xerox machines purchased by

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[1] *See, e.g., De Lima* v. *Bidwell,* 182 U.S. 1, 197 (1901); *Pickhardt* v. *Merritt,* 132 U.S. 252, 257 (1889); *Newman* v. *Arthur,* 109 U.S. 132, 138 (1883); *Cain* v. *Bowlby,* 114 F.2d 519, 522 (10th Cir.), *cert. denied,* 311 U.S. 710 (1940); *Todd* v. *Citizens' Gas Co.,* 46 F. 2d 855, 865 (7th Cir.), *cert. denied,* 283 U.S. 852 (1931); *Jerome H. Remick & Co.* v. *Am. Auto. Accessories Co.,* 5 F.2d 411 (6th Cir.), *cert. denied,* 269 U.S. 556 (1925); *Commonwealth* v. *Tilley,* 306 Mass. 412, 415-16, 28 N.E.2d 245, 247 (1940).

[2] 312 U.S. at 339-40 (footnotes omitted).

[3] *Jerome H. Remick & Co.* v. *Am. Auto. Accessories Co.,* 5 F.2d 411 (6th Cir.), *cert. denied,* 269 U.S. 556 (1925).

libraries are entitled to the 13c exemption even though schools and libraries may not have used such equipment in 1938. Guitars purchased for a church "Folk Mass" are for the church's "own use," and hence are also within the 13c exemption, even if such a church function was unheard of in 1938.

Similarly, drugs used by nonprofit hospitals today are entitled to the 13c exemption even when purchased for uses which had not developed, or were not widespread, in 1938.

As this Court has stated:

> "While statutes should not be stretched to apply to new situations not fairly within their scope, they should not be so narrowly construed as to permit their evasion because of changing habits due to new inventions and discoveries."[1]

If the beneficent purpose of the Nonprofit Institutions Act is to be realized, and if public service institutions are to operate inexpensively, as the Congress intended, the exemption must be coextensive with the present-day functions of the beneficiary institutions.

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[1] *Fortnightly Corp.* v. *United Artists Television, Inc.,* 392 U.S. 390, 395 n.16 (1968).

II.

The Ninth Circuit Decision Ignores the Realities of Present-Day Medical Practice.

The decision of the Court of Appeals is incompatible with the functions of a hospital in contemporary society. The hospital today occupies the central position in the health care system.[1] It is no longer a facility devoted chiefly to the care of inpatients, the acutely ill, or the indigent; it is now a health center "encompassing and integrating the wide range of comprehensive medical services—prevention, treatment, rehabilitation, and aftercare."[2]

The expanded role has, in large part, been thrust upon hospitals.[3] In recent decades, a confluence of factors—*e.g.*, demographic changes, shortages of general practitioners (particularly in inner city and rural communities), the increasing inability of many to afford private medical care, and the trend toward physician specialization—have caused critical problems in the delivery of health care.[4]

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[1] *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 506 F.2d 1278, 1288 (D.C. Cir. 1974), *cert. granted*, 95 S. Ct. 1974 (1975) (Nos. 74-1110 and 74-1124).

[2] H. M. & A. R. Somers, Medicare and the Hospitals—Issues and Prospects 43 (1967). *See also*, Editorial, *The Hospital's Responsibility for Primary Care*, 2 Hosp. Med. Staff, Jan., 1973, at 1.

[3] Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, Center for Community Health Systems, Columbia University, Community Hospitals and the Challenge of Primary Care 15 (1975).

[4] See Appendix 1, *infra*, for a summary of factors causing the increase in ambulatory visits to hospitals, reprinted from Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, Center for Community Health Systems, Columbia University, Community Hospitals and the Challenge of Primary Care 18-19 (1975).

Inevitably, it has been the hospital to which the community has turned for the solution to the growing crisis.[1] In 1965, the Board of Trustees of the American Hospital Association summarized the need for change this way:

> "[The] changing needs of the public are demanding a changing hospital.
>
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> " . . . *The hospital now must be . . . an organized arrangement of all medical resources* necessary to bring the individual, wherever located, into contact with the skills of the physician and other members of the health care team. It must serve as an arrangement by which our communities . . . make available medical, nursing, and other professional care for the prevention, diagnosis, and treatment of disease, and eventually for the rehabilitation of the sick and injured, when these resources are beyond the capabilities of the individual patient or physician. . . . *This hub, the general hospital, cannot function independently of the other elements within the circle of organized hospital care activity, such as the outpatient departments, emergency departments, home care programs, and long-term care facilities.*"[2]

AHA's analysis was not revolutionary. The concept of the hospital as the hub of community health care services has been urged by health care authorities for years.[3] Today, Federal agencies and commissions, along with pri-

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[1] *See* Somers, *Only the hospital can do it all—now*, 119 Mod. Hosp., July, 1972, at 95.

[2] 39 Hosp., July 1, 1965, at 35a (emphasis supplied). *See* Brodie & Graber, *Institutional Pharmacy Practice in the 1970's*, 28 Am. J. Hosp. Pharmacy 240, 241 (1971).

[3] Somers, *Only the hospital can do it all—now*, 119 Mod. Hosp., July, 1972, at 96.

vate health care experts, forcefully advocate health care facilities which place "particular emphasis on primary, ambulatory care." [1]

Congress, too, has consistently urged the expansion of ambulatory health care facilities.[2]

In response to such urging, hospitals have substantially expanded their outpatient and ambulatory services. Last year, nearly a quarter of a billion outpatient visits were made to U.S. hospitals—more than one for every American.

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[1] NATIONAL ADVISORY COMMISSION ON HEALTH FACILITIES—A REPORT TO THE PRESIDENT (1968). *See also* NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FINANCIAL PLANNING IN AMBULATORY HEALTH PROGRAMS, Publication No. (HSM) 73-3027 (1973); REPORT OF THE NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES (1967); DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES 4 (1967); CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE (1975); Editorial, 215 J.A.M.A. 972 (1971). Even the Cost of Living Council took steps to encourage ambulatory care when, in 1974, it issued revised price regulations for hospitals "[i]n order not to discourage the trend towards increased use of outpatient services." 39 Fed. Reg. 2670, 2697 (1974).

[2] For example, in connection with the Public Health Service Amendments of 1968, Pub. L. No. 90-574, 82 Stat. 1005, Congress noted the need for "ambulatory-care facilities, such as outpatient departments of hospitals . . . to negate the necessity of constructing additional inpatient facilities and . . . to control the cost of delivering medical care." S. Rep. No. 1454, 90th Cong., 2d Sess. (1968). Two years later, in the Medical Facilities Construction and Modernization Amendments of 1970, 42 U.S.C. § 291e(a)(5), Congress specifically provided by statute that priority in construction be given "to projects for facilities which . . . will . . . [include] outpatient and preventive care as well as hospitalization." And only recently, Congress complained in Section 2(a)(4) of the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2226, that "there are presently inadequate incentives for the . . . substitution of ambulatory and intermediate care for inpatient hospital care."

On an average day, 87,000 people are admitted as inpatients to community hospitals, while nearly half a million people are treated in these hospitals' clinics and emergency rooms. There were 2.3 ambulatory visits for every inpatient admission in 1953; the ratio has now more than doubled to 5.6 to 1. And the trend is continuing. From 1968 to 1973 alone, the number of visits has increased by 57 percent.[1] It is clear that

> "care of the ambulatory patient for both minor ailments and serious illnesses has become a major function of the modern hospital establishment and a significant part of general medical care for large numbers of people." [2]

III.

The Decision Below Draws Distinctions Which Are Arbitrary and Illusory.

The Ninth Circuit decision ignores the foregoing developments and the manifold role of today's hospital in the delivery of health care services. It holds that drugs are purchased for the hospital's "own use" and are entitled to the Section 13c exemption only when the drugs are consumed by persons lying in a horizontal position—in a hospital bed or in the emergency clinic. The drugs consumed by persons in a vertical position—upon discharge from the hospital or in an outpatient clinic—are denied the Section 13c exemption. This makes no sense.

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[1] Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE 16 (1975).

[2] *Id.*

Even if hospitals provided only inpatient care, this distinction would be arbitrary. But in light of the functions of a modern hospital—where outpatient care is an integral part of hospital health care services—the distinction is absurd.

The Court of Appeals explained its result as follows:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of inpatients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." 510 F.2d at 489.

This explanation merely restates the result.

Hospitals necessarily use drugs in treating inpatients and outpatients. The hospital's use of drugs in both cases is identical. In neither case does the hospital "consume" the drug. It is the patient—inpatient or outpatient—who does so. In both cases the hospital purchases the drug for resale to the patient. And in both cases the hospital is engaging in a "proper hospital function," as the Court of Appeals conceded. By what logic, then, can the Section 13c exemption be accorded to drugs used to treat inpatients but denied to drugs used to treat outpatients?

The decision confers the Section 13c exemption upon drugs used in the emergency clinic but denies the exemption to drugs used in the outpatient clinic. Yet study after study has shown that, in most urban hospitals, the emergency clinic doubles for all practical purposes as an outpatient clinic.[1] On what rational basis, then, can it be determined that drugs provided to patients in the emergency clinic are for the hospital's "own use," whereas drugs provided to patients in a hospital outpatient clinic are not?

The rigid lines drawn between inpatients and outpatients, between emergency clinics and outpatient clinics, and between other exempt and nonexempt categories are nowhere explained in the decision. They are, in fact, inexplicable.

IV.

The Decision Would Adversely Affect Nonprofit Hospitals—the Intended Beneficiaries of Section 13c—and the General Public.

A. *Compliance With the Decision Would Be Burdensome*

Section 13c was intended to confer substantial benefits upon hospitals and other nonprofit institutions. The decision of the Court of Appeals, however, would convert Section 13c benefits into burdens of considerable consequence.

How would a hospital attempt to comply with the decision? We see only four possibilities, all of them objectionable:

(1) A hospital could set up and maintain dual inventories and distribution systems for drugs and other hos-

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[1] Bodenheimer, *Patterns of American Ambulatory Care*, VII INQUIRY, Sept., 1970, at 26, 33; Perkoff and Anderson, *Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, VIII MED. CARE 309 (1970) and studies cited therein.

pital supplies, one for "their own use" uses, within the meaning of the Court of Appeals decision, and the other for other proper hospital uses. The substantial costs and burdens of a double inventory system are obvious. It would require duplication of all supply functions and procedures—requisitions, bidding processes, purchase orders, accounting records, inventory, storeroom space, personnel and so on—for the thousands of different drugs and dosage forms typically stocked by a hospital pharmacy and for the many other supplies which hospitals purchase. The burden would be even greater in the large hospital which operates a number of satellite pharmacies within the hospital in order to distribute drugs more effectively.

(2) Alternatively, a hospital might be obligated to trace the uses to which a single inventory of hospital pharmaceuticals or other supplies are put, subsequently securing a rebate for items allocated to "for their own use" uses, or paying a surcharge for items allocated to other proper purposes. This arrangement, however, would be a formidable administrative task. Keeping track of the use to which all hospital supplies are put would be an extraordinary undertaking in view of the quantity of drugs and other supplies stocked by the hospital. Moreover, hospitals obtain their supplies from a variety of sources—manufacturers, wholesalers, distributors, jobbers and the like. Also, it is common for hospitals to purchase a single product from more than one supplier. It would be an extraordinary chore to determine which supplier owes a rebate to the hospital or is due a surcharge from the hospital.

(3) A hospital could simply pay higher prices for *all* of its prescription drugs and other supplies. This alternative would considerably increase the cost of hospital

operations, which are already high, and inevitably result in higher hospital bills to hospital patients and the public.

The taxpayers of this country already pay considerable sums of money to finance the cost of drugs dispensed through nonprofit hospitals. In fiscal year 1972-73, the Federal Government and the state governments spent $670 million for the drugs and drug sundries provided in connection with national health programs.[1] This amount would rise significantly if the Section 13c exemption were limited in the fashion prescribed by the Court of Appeals.

(4) Finally, a hospital might, at least in theory, eliminate its "nonexempt" functions, *e.g.,* its outpatient clinic and ambulatory care services. As we have already demonstrated, however, such services need to be expanded, not scuttled.

The decision of the Court of Appeals, if allowed to stand, would thus confront nonprofit hospitals with a series of extraordinarily onerous and unacceptable alternatives.

B. *Compliance With the Decision Would Be Costly*

No matter which course the hospital and its suppliers might take as a result of the decision below, the impact upon the public would be the same: higher hospital costs. The cost of hospital care will inevitably rise if hospitals must maintain double inventories, or pay higher prices for their supplies, or incur needless additional administrative expenses, or lose Section 13c prices entirely.

The Government, and ultimately, the taxpayer, would be obliged to pay more for hospital care. Medicaid costs, which cover outpatient prescription costs, would increase.

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[1] 37 Soc. Sec. Bull. No. 2, Table 2, p. 7 (February 1974).

The Government cost of financing various health programs administered by nonprofit hospitals—such as the migrant health program, 42 U.S.C. § 242h (Supp. III, 1973), and the Indian health program, 42 U.S.C. § 2002 (1970)—would also increase. Should Medicare be extended to cover outpatient prescriptions, the cost of that program would increase as well.

C. *The Decision Would Discourage Section 13c Prices for Any Supplies*

Even more distressing is the prospect that drug manufacturers and other hospital suppliers might feel compelled by the decision to discontinue all Section 13c special low prices. They might be unwilling to police their customers' distribution practices, or bear any risk of Robinson-Patman Act exposure. Should suppliers take this course, hospital expenses would soar, with consequent cost increases to those in need of medical care. All government medical assistance programs would suffer substantial cost increments across the board. And, of course, the purpose of the Section 13c exemption would be totally frustrated.

D. *The Decision Would Constrain the Development of Necessary Health Care Services*

The decision would frustrate the beneficent purposes of the Section 13c exemption in still another way—by denying hospitals the flexibility they require to respond to the needs of the communities they serve.

The categorical approach of the Court of Appeals is inappropriate and unworkable. The opinion does not merely determine the applicability of the Section 13c exemption to a particular drug sale, or a particular hospital, in particular factual circumstances. Instead, the decision attempts to identify every type of drug use by hospitals,

and to grant or deny the Section 13c exemption to each identified type of use in absolute, categorical fashion. The Section 13c exemption is simply not susceptible to this cubbyhole mode of analysis.

First, the eight categories of drug use listed in the Court of Appeals decision are insufficient to cover even the present range of hospital drug usage.[1] As hospitals continue to evolve, and as new modes of treatment are developed, it is inevitable that additional drug uses—not covered by the eight category analysis—will appear.

Second, the categories would impose arbitrary limits upon the application of the Section 13c exemption. Thus,

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[1] For example, the following common hospital uses do not fall within any of the eight categories considered by the Court of Appeals:

Example No. 1—drugs given to psychiatric inpatients released "on pass." Such inpatients are encouraged to spend weekends with family, but they must maintain their prescribed medication routine while out of the hospital;

Example No. 2—drugs administered to outpatients in the course of treatment at the clinic, on a one-time-only basis. For example, a physician at the clinic may administer an initial dose of penicillin to an outpatient by injection, and prescribe follow-up oral medication to be taken at home;

Example No. 3—drugs provided to outpatients for administration *in the hospital.* Oftentimes, such drugs, though available in neighborhood pharmacies, require special administration by a professional or require observation of the patient by a professional to guard against untoward reactions;

Example No. 4—drugs administered or dispensed to outpatients in the course of home treatment *by hospital physicians and staff.* As an extension of its inpatient and outpatient care services, an increasing number of hospitals administer home-care programs whereby professional staff of the hospital treat patients in the patients' own homes; and

Example No. 5—drugs provided to patients of affiliated extended care institutions where, by agreement, the hospital is responsible for certain aspects of patient care.

one category would disallow Section 13c benefits on sales to walk-ins—without regard to whether the sale is at noon on a business day or at midnight on a holiday weekend. Another category would disallow Section 13c benefits to all outpatients, whether or not the medication they require is even available in commercial pharmacies.

Respondents have argued that the Court of Appeals decision would not bar hospitals from providing drugs to the departing inpatient, the outpatient, the walk-in, or others in the non-exempt categories. But the Hobson's choices imposed by the Ninth Circuit decision may well constrain hospitals from providing services to those categories of patients.

Hospitals which presently lack ambulatory or outpatient facilities might simply decide not to open them. Other hospitals, anxious to avoid duplicate inventories and bookkeeping, might simply decide to discontinue take-home prescriptions or sales to walk-ins.

Surely the Congress did not intend that Section 13c serve to burden, rather than benefit, nonprofit institutions. Nor did the Congress intend that Section 13c deter any nonprofit institution from performing anything less than the maximum amount of public service.

The decision of the Court of Appeals would frustrate rather than further the purpose of the Nonprofit Institutions Act. It should be reversed.

V.

The Proper Section 13c Test Is Whether the Primary Purpose of the Hospital's Purchase of Supplies Is the Treatment of Its Patients or the Performance of Other Legitimate Hospital Functions.

The deficiencies in the Court of Appeals opinion will not be cured by moving the line separating "exempt" and "non-exempt" categories, or by adding additional categories of drug use. The fundamental flaw in the decision is its cubby-hole approach. The scope of the Section 13c exemption should be determined in entirely different fashion.

The controlling question should be the *primary purpose* of the purchase by the hospital: is it for the treatment of hospital patients or the performance of other legitimate hospital functions? If so, we submit, the Section 13c exemption should apply.

This functional approach to Section 13c was utilized, ironically, by the Ninth Circuit in *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967). In that case, the court considered whether the sale of bowling lanes and equipment to the Utah State University by Brunswick at lower prices than it charged plaintiff for similar equipment constituted a violation of the Robinson-Patman Act. Plaintiff contended that the Section 13c exemption was inapplicable. It argued that because the student bowling alleys were open to and used by the public, the purchase of the bowling lanes was not for the University's "own use."

The Court of Appeals emphatically rejected that argument:

> *"The primary purpose of the purchases* established beyond dispute, was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff. This being the case, any additional use of the bowling facilities by the general public for a fee, even if such use is substantial, would not establish that the purchases were not made for the use of the University."[1]

The primary purpose test is eminently sensible and should be endorsed by this Court:

First, the primary purpose test fulfills the intent of Congress. Section 13c was intended to benefit nonprofit institutions by enabling them "to operate as inexpensively as possible."[2] As we have demonstrated, however, the Ninth Circuit's categorical test would transform benefits into burdens. The primary purpose test would accord nonprofit institutions the price benefits Congress intended to confer without shackling their ability to fulfill their institutional purposes.

Second, the primary purpose test would not oblige the judiciary to decide what functions a hospital—or a church or school or library—should or should not perform. The court in *Logan Lanes* accepted without challenge the university's decision to provide bowling facilities for its students, faculty and staff. The court did not try to second-guess the institution's own determination of what functions it should serve, or what supplies it should purchase—for its "own use"—to fulfill those functions.

Third, the primary purpose test would make it unnecessary for the judiciary to attempt the impossible, that is,

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[1] 378 F.2d at 217 (emphasis supplied).

[2] *Id.* at 216.

the identification and quantification of every use to which every school, library, church and hospital purchase is put. Once it was established in *Logan Lanes* that the "primary purpose" of the purchases was to "fulfill the needs" of the institution, the court ruled as a matter of law that the purchases were for the institution's "own use," without inquiring further into what collateral uses may have been made of the purchased supplies.[1]

By contrast, the decision below would apparently require judicial scrutiny of all uses of all supplies purchased by nonprofit institutions. The categorical test would compel courts to separate out (1) uses for proper institutional purposes and (2) uses "for their own use"; only the latter would be entitled to the Section 13c exemption.

The application of the primary purpose test would put an end to the illusory distinction between purchases for a hospital's "proper function" and a hospital's "own use." It would provide a sensible result in the instant case, and a workable foundation for subsequent interpretations of Section 13c. And it would best effectuate Congress' intent in granting a Robinson-Patman exemption to nonprofit institutions.

For these reasons, we urge the Court to reject any categorical test and to adopt the primary purpose test employed in *Logan Lanes.*

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[1] The Internal Revenue Service has adopted a similarly sensible test for determining whether a hospital is engaging in an unrelated business through its sale of drugs to various persons. The IRS test is whether the drugs are sold to *patients* of the hospital. In-patients, outpatients, discharged patients, patients receiving medical services as part of a home care program or in an extended care facility—all have been deemed to be "patients" of the hospital. See Rev. Rul. 68-376, 1968-2 CUM. BULL. 246, reproduced in Appendix 2, *infra.*

VI.

The "Primary Purpose" Test Would Accord the Section 13c Exemption to the Drug Purchases in Issue.

The record shows that the drugs in issue in this case were purchased primarily for the treatment of hospital inpatients and outpatients. During the most recent twelve month period for which there is evidence in the record, over 97% of all drug sales by nine Portland hospitals were made to inpatients and outpatients.[1] Since the drugs were purchased primarily for the purpose of treating hospital patients, we submit that all such drug purchases are covered by the Section 13c exemption.

Drug therapy is unquestionably an integral part of medical care:

> "The development of medical care in the last several decades is, in part attributable to the development and distribution of new drugs and medicines. The advent of the miracle drugs, such as antibiotics, tranquilizers, analgesics, and other new therapeutic substances, has increased the length of life, reduced communicable disease, eased the burdens of chronic disease and mental illness, and relieved much pain and discomfort. At the same time, the pharmaceutical armamentarium that has become available reduces the total cost and time of treatment for many illnesses."[2]

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[1] See Tr. 5/25/73 at 16-17.

[2] DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, INCLUSION OF PHARMACEUTICAL SERVICES IN HEALTH MAINTENANCE AND RELATED ORGANIZATIONS, DHEW Publication No. (HSA) 74-13017, at 4 (1974).

Thus, the sale of drugs is an "inseparable component of the *service* provided by" a hospital.[1]

The dispensing of drugs to departing inpatients, outpatients and other sick people is no less a component of the therapeutic service provided by a hospital than the dispensing of drugs to inpatients. As one authority has observed:

> "If we believe that the pharmacist should be in the inpatient care area and contribute his knowledge to improved standards of care, should not ambulant patients receive the same benefit from the pharmacist's services? A double standard of care cannot be condoned."[2]

Admittedly, hospitals dispense drugs to inpatients and emergency room patients of necessity. Alternative sources of supply are unavailable to the bedridden. But this distinction provides no basis on which to condition the application of the Section 13c exemption.[3] The controlling fact is that drugs are dispensed to departing inpatients, outpatients, and other sick people for the very same pur-

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[1] *Hospital Building Co.* v. *Trustees of Rex Hospital*, 511 F.2d 678, 683 (4th Cir. 1975), *petition for cert. filed*, 43 U.S.L.W. 3626 (U.S. May 19, 1975) (No. 74-1452).

[2] Brodie & Graber, *Institutional Pharmacy Practice in the 1970's*, 28 AM. J. HOSP. PHARMACY 240, 244 (1971).

[3] The Robinson-Patman Act only prohibits price discriminations which cause competitive injury. F. ROWE, PRICE-DISCRIMINATION UNDER THE ROBINSON-PATMAN ACT 19 (1962). Congress would have had no reason to enact the Nonprofit Institutions Act if the scope of the Section 13c exemption was to be limited to instances in which the nonprofit institution is not in competition with any other institution.

pose that they are dispensed to inpatients and emergency room patients—to make them well.[1]

There are special reasons why hospitals should dispense drugs to outpatients. Hospital dispensing encourages patient compliance with the medication regimen. Studies have disclosed a significant incidence of patient noncompliance with drug therapy routines.[2]

> "In our present health care system primary emphasis is placed on diagnosis and then the prescribing of a certain course of therapy for the patients. What happens from this point on has largely been a matter of chance. Whether the prescription is ever filled, whether the patient takes the medication as directed, or whether

[1] The Internal Revenue Service has looked to the therapeutic rationale for various hospital operations to determine whether they constitute unrelated businesses. In ruling on the tax exempt status of hospital parking lots, the IRS concluded:

> "One of the purposes of the hospital is to provide health care for members of the community. Visitation of patients constitutes supportive therapy that assists in patient treatment and encourages their recovery. Without adequate parking facilities for patients and visitors, the hospital could not operate with maximum effectiveness in serving the public." Rev. Rul. 69-269, 1969-1 CUM. BULL. 160, 161.

In addition, the IRS has considered whether such operations will increase the efficiency of the hospital. Thus, "the sale of . . . personal effects by the gift shop to hospital personnel" was held to contribute importantly to the hospital's exempt purpose because "it is to the hospital's advantage to keep its employees and medical staff on its premises throughout their working days." Rev. Rul. 69-267, 1969-1, CUM. BULL. 160. This same reasoning would find the sale of pharmaceutical supplies to hospital staff and employees to be within the scope of the Section 13c exemption, even without regard to the primary purpose test. *See also,* Rev. Rul. 69-268, 1969-1 CUM. BULL. 160.

[2] *See* Sharpe & Mikeal, *Patient compliance with antibiotic regimens,* 31 AM. J. HOSP. PHARMACY 479 (1974); Marston, *Compliance With Medical Regimens: A Review of the Literature,* 19 NURSING RESEARCH 312 (1970).

> he is also taking other medication that may interact, has been open to speculation."[1]

Obviously, the probability that a patient will obtain and take his prescribed medicine is increased if a pharmacy is located in the outpatient clinic. In addition, the prospect of errors in the administration of the medication is minimized if instructions are provided by the dispensing pharmacist.[2] Studies have confirmed that patient-pharmacist counseling "is an effective means for improving patient compliance and understanding of the medication regimen."[3]

In sum, the drugs in issue here were purchased primarily for the purpose of treating hospital patients, outpatients as well as inpatients. This is a proper hospital purpose. Accordingly, all of the drug purchases in issue are exempted from the provisions of the Robinson-Patman Act by Section 13c.

[1] Stewart & Cluff, *A review of medication errors and compliance in ambulant patients,* 13 CLINICAL PHARMACOLOGY AND THERAPEUTICS 463, 465 (1972).

[2] "Patients should receive more complete instructions concerning the proper use of medication. In our society, better instructions are provided when purchasing a new camera or automobile than when the patient receives a lifesaving antibiotic or cardiac drug. The hospital provides an excellent setting for teaching patients about the use of prescription and nonprescription drugs." *Id.* at 467.

[3] Madden, *Evaluation of Outpatient Pharmacy Patient Counselling,* NS13 J. AM. PHARMACEUTICAL ASS'N 437, 442 (1973).

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges that this Court reverse the decision of the Court of Appeals and reinstate the decision of the District Court.

Respectfully submitted,

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APPENDIX

APPENDIX 1*

Figure 1-1. Cause of the Increase in Ambulatory Visits to Hospitals

Demographic, social, and economic shifts

1. Population increase of about 2 percent per annum
2. Aging of the population
3. Increasing prevalence of chronic diseases
4. Rise in accident rates
5. Large concentrations of low income groups in metropolitan areas with few physicians
6. Inability to afford private medical care
7. High level of geographic mobility with substantial numbers of patients without a regular family doctor
8. Increase in numbers of persons who visit a hospital outpatient facility for minor conditions previously treated at home

Reduced availability and accessibility of primary care

1. Decrease in the number of general practitioners who function as the primary care physician of first contact
2. Private physicians dying or leaving inner-city areas to relocate elsewhere and not being replaced

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* Reprinted from Piore, ***Problems and Opportunities for Community Hospitals in Primary Care,*** CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE 18-19 (1975).

3. Increasing unavailability of physicians at night or on weekends or holidays
4. Reluctance of physicians to make house calls
5. Unwillingness of patients to inconvenience private physicians outside of office hours
6. Increasing physician specialization, accompanied by patient's confusion about which specialist to call, arrangement of office hours by appointment only, physician's unwillingness to accept responsibility for a patient's problem outside his field of interest
7. Decrease in independent capacity of the physician to treat emergency conditions optimally in his office, as a consequence of the increase in medical science and technology

Institutionalization of medical care in hospitals

1. Historical change in role of hospital from last resort of the dying, to the workshop of the physician for all serious illness, then to the function of community health center
2. Availability in hospital of complex and costly equipment operated by highly skilled personnel
3. Physician's acceptance of hospital emergency facility, in preference to his office, as a place of treatment of injuries, acute illnesses, and even some non-acute conditions
4. Increased public awareness of the hospital as an appropriate place to seek care and greater confidence in its outpatient facilities

5. Informal, non-appointment, casual medical care relinquished to hospital
6. Availability of round-the-clock medical care, which hospital may be legally required to provide
7. Accessibility of hospitals to the highly concentrated urban population

Changes in insurance plans and public attitudes

1. Extension of benefits by many health insurance plans to services rendered in emergency departments but not to those rendered in office visits or house calls
2. Growing tendency for industries, schools, and police to refer patients to the emergency facility
3. People's increasing sophistication in identifying symptoms and perceiving the immediacy with which they should be treated by a physician
4. Absence of effective screening at the various entry points to the emergency medical system, with the result that many non-urgent patients are entering the system

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Source: Adapted from M. L. Webb, "The Emergency Medical Care System in a Metropolitan Area," Department of Public Health Thesis, School of Hygiene and Public Health, Johns Hopkins University, 1969.

APPENDIX 2

REV. RULING 68-376, 1968-2 CUM. BULL. 246

The Internal Revenue Service has been requested to set forth situations in which persons who purchase pharmaceutical supplies from the pharmacy of a hospital exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954 are considered "patients" of the hospital within the meaning of section 513 (a)(2) of the Code.

Section 513 of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of an organization for income or funds or the use it makes of the profits derived) to the exercise or performance by an organization of its exempt functions. However, to the extent relevant here, section 513(a)(2) of the Code further states that such term does not include any trade or business which is carried on by an organization described in section 501(c)(3) primarily for the convenience of its patients.

In the case of a hospital exempt under section 501(c)(3) of the Code, the sale of pharmaceutical supplies by its pharmacy to persons considered "patients" of the hospital does not constitute unrelated trade or business as defined in section 513 of the Code. See section 1.513-1(c)(2)(ii) of the Income Tax Regulations. Depending upon his relationship with the hospital, a purchaser of pharmaceutical supplies from the pharmacy of a hospital exempt from Federal income tax under section 501(c)(3) of the Code may be considered a "patient" of the hospital as that term is used in section 513(a)(2) of the Code.

Examples of relationships that determine whether a person is a "patient" of a hospital for purposes of section 513(a)(2) of the Code are illustrated in the six situations set out below.

Situation 1—A person admitted to a hospital as an inpatient.

A is admitted to the hospital as an inpatient. He receives bed, meals, diagnostic services, and treatment for his illness. He is a "patient" of the hospital.

Situation 2—A person receiving general or emergency diagnostic, therapeutic, or preventive health services from outpatient facilities of a hospital.

B is taken to the hospital's emergency room for treatment of injuries sustained in an accident. He is treated in the emergency room and discharged, but is told to return to the hospital's outpatient clinic for further treatment. The hospital maintains an outpatient clinic having regularly scheduled hours during which medical services are provided on an outpatient basis. The governing authority of the hospital has full legal responsibility for the conduct of the clinic. *B* visits the clinic, is registered as a patient, and receives medical care. Treatment in either the emergency room or the outpatient clinic is sufficient to make *B* a "patient" of the hospital.

Situation 3—A person directly referred to the hospital's outpatient facilities by his private physician for specific diagnostic or treatment procedures.

C's private physician refers him to the hospital's outpatient diagnostic facilities for a specific diagnostic pro-

cedure. The procedure is administered by a hospital-based practitioner affiliated with the hospital. The availability of these diagnostic procedures is an integral part of the services offered by the hospital. *C* is a "patient" of the hospital.

Situation 4—A person refilling a prescription written during the course of his treatment as a patient of the hospital.

D was formerly a patient of the hospital. During his course of treatment the attending staff physician gave *D* a prescription. *D* filled the prescription at the hospital pharmacy, which filed and retained it. After formal discharge as a patient, he finds it convenient to return to the hospital pharmacy to obtain a refill of that prescription. Since the prescription was written in the course of the hospital-patient relationship, *D* is a "patient" of the hospital.

Situation 5—A person receiving medical services as part of a hospital administered home care program.

E receives medical services in his residence. The services are rendered by, and under the supervision of, the professional staff of the hospital as an extension of its inpatient and outpatient care. *E* is a "patient" of the hospital.

Situation 6—A person receiving medical care and services in a hospital-affiliated extended care facility.

F is a patient in an extended care facility qualified to participate in Medicare and other government financed programs. The facility is affiliated with the hospital which,

by agreement, is responsible for certain of its professional activities, especially those necessary to qualify the facility for participating in the Medicare program. While a patient in the facility, *F* is under the medical supervision of a member of the hospital's medical staff and thus is a "patient" of the hospital.

Accordingly, sales of pharmaceutical supplies to the "patients" in each of the situations described do not constitute unrelated trade or business of the hospital within the meaning of section 513 of the Code.

See Revenue Rulings 68-374 and 68-375, pages 242 and 245 of this Bulletin, for other situations involving sales of pharmaceutical supplies by pharmacies operated by hospitals.